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HEALTH AND HUMAN SERVICES

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Health and Human Services**

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Preface

This reference booklet provides significant summary information about health expenditures and Centers for Medicare & Medicaid Services (CMS) programs. The information presented was the most current available at the time of publication. Significant time lags may occur between the end of a data year and aggregation of data for that year.

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Highlights

Growth in CMS programs and health expenditures

Populations

- Persons enrolled for Medicare coverage increased from 19.5 million in 1967 to a projected 40.0 million in 2001, a 105 percent increase.
- The number of Medicaid enrollees at any period in 2001 is estimated to be about 34.3 million, the greater majority of whom are children (17.0 million or nearly 50 percent).
- At any point of time, about 12 percent of the population is enrolled in the Medicaid program.
- Medicare enrollees with end-stage renal disease increased from just under 67 thousand in 1980 to 292 thousand in 2000, an increase of 336 percent.
- Medicare State buy-ins have grown from about 2.8 million recipients in 1975 to over 5.5 million recipients in 2000, an increase of about 95 percent.

- The number of dually entitled persons (that is, persons covered by both Medicare and Medicaid) amounted to about 6 million persons for 2000.

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,707 in December 1975 to 6,031 in December 2000. Total inpatient hospital beds have dropped from 51.5 beds per 1,000 enrolled in 1975 to 25.4 in 2000, a decrease of 51 percent.
- The total number of Medicare certified beds in short-stay hospitals showed a steady increase from less than 800,000 at the beginning of the program and peaked at 1,025,000 in 1984-86. Since that time, the number has dropped to 863,000.
- The number of psychiatric hospitals grew to about 400 by 1976, where it remained until the start of the prospective payment system (PPS) in 1983. After PPS, the number increased to over 700 in the early 1990's and has since dropped to 519.
- The number of skilled nursing facilities (SNFs) increased rapidly during the 1960s, decreased during the first half of the 1970s, and has generally been increasing ever since, leveling off at around 14,800.
- After peaking in December 1970, the number of home health agencies (HHAs) remained stable during most of the decade. The number of HHAs accelerated with the passage of the Omnibus Budget Reconciliation Act of 1980, which permitted the certification of proprietary HHAs in States not having licensure laws. By December 1986, there were

almost 6,000 participating facilities. The Balanced Budget Amendment of 1997 has impacted significantly on the number of participating HHAs. Between 2000 and 2001, the number of HHAs has decreased from 7,857 to 7,099, a decrease of 9.6 percent.

Expenditures

- National health expenditures were \$1,299.5 billion in 2000, 13.2 percent of the gross domestic product. By 2001, total CMS program outlays were \$351.6 billion, 18.9 percent of the Federal budget.
- Medicare skilled nursing facility benefit payments increased from \$10.6 billion in 2000 to \$12.4 billion in 2001.
- Medicare home health agency benefit payments increased slightly between 2000 and 2001 from \$9.2 billion to \$9.3 billion.
- National health expenditures per person were \$205 in 1965 and grew steadily to reach \$4,637 by 2000.

Utilization of Medicare and Medicaid services

- Between 1990 and 2000, the number of short-stay hospital discharges increased from 10.5 million to 11.8 million, an increase of 12 percent.
- The short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 6.0 days in 2000, a decrease of 33 percent. Likewise, the average length of stay for excluded units decreased significantly from 19.5 days in 1990 to 12.3 days in 2000, a decrease of 37 percent.

- About 29 million persons received a reimbursed service under Medicare fee-for-service during 1999. Comparably, over 40 million persons used Medicaid services or had a premium paid on their behalf in 1999.
- The ratio of Medicare aged users of any type of covered service has grown from 367 per 1,000 enrolled in 1967 to 921 per 1,000 enrolled in 1999.
- 6.8 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 1999.
- 28.4 million persons received reimbursable fee-for-service physician services under Medicare during 1999. 18.4 million persons received reimbursable physician services under Medicaid during 1999.
- 20.6 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 1999. During 1999, 12.3 million persons received Medicaid reimbursable outpatient hospital services.
- Over 1.4 million persons received care in SNFs covered by Medicare during 1999. 1.7 million persons received care in nursing facilities, which include SNFs and all other intermediate care facilities other than mentally retarded, covered by Medicaid during 1999.
- Almost 20 million persons received prescribed drugs under Medicaid during 1999.

Populations

Information about persons covered by Medicare or Medicaid

For Medicare, statistics are based on persons enrolled for coverage. Historically, for Medicaid, recipient counts were used as a surrogate of persons eligible for coverage, as well as for persons utilizing services. Current data systems now allow the reporting of total enrollees. Statistics are available by major program categories, by demographic and geographic variables, and as proportions of the U.S. population. Utilization data organized by persons served may be found in the Utilization section.

Table 1
Medicare enrollment/trends

	Total persons	Aged persons	Disabled persons
July	In millions		
1966	19.1	19.1	--
1970	20.5	20.5	--
1975	24.9	22.7	2.2
1980	28.4	25.5	3.0
1985	31.1	28.1	2.9
1990	34.3	31.0	3.3
1995	37.6	33.2	4.4
1997	38.4	33.6	4.8
1998	38.8	33.8	5.0
1999 ¹	39.2	34.0	5.2
2000 ¹	39.6	34.2	5.4
2001 ¹	40.0	34.4	5.6
2002 ¹	40.4	34.6	5.8

¹Data for 1966-1998 are as of July. Data for 1999-2002 represent average monthly estimates.

NOTE: Numbers may not add to totals because of rounding.

SOURCES: CMS, Office of Information Services and Office of the Actuary.

Table 2
Medicare enrollment/coverage

	HI and/or SMI	HI	SMI	HI and SMI	HI only	SMI only
	In millions					
All persons	39.6	39.2	37.3	36.9	2.3	0.4
Aged persons	34.2	33.8	32.5	32.1	1.7	0.4
Disabled persons	5.4	5.4	4.8	4.8	0.6	(¹)

¹Number less than 500.

NOTE: Average monthly enrollment during calendar year 2000.

SOURCE: CMS, Office of the Actuary.

Table 3
Medicare enrollment/demographics

	Total	Male	Female
	In thousands		
All persons	39,620	17,126	22,494
Aged	34,253	14,112	20,141
65-74 years	17,776	8,080	9,696
75-84 years	12,155	4,795	7,360
85 years and over	4,322	1,237	3,085
Disabled	5,367	3,014	2,353
Under 45 years	1,652	965	687
45-54 years	1,627	917	710
55-64 years	2,088	1,132	956
White	33,747	14,563	19,184
Black	3,728	1,577	2,151
All Other	2,146	986	1,160
Native American	66	32	34
Asian/Pacific	535	236	299
Hispanic	911	434	477
Other	526	247	279
Unknown Race	108	37	71

NOTES: Data as of July 1, 2000. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Information Services.

Table 4
Medicare enrollment/end stage renal disease trends

	HI and/or SMI	HI	SMI
	In thousands		
Year			
1980	66.7	66.3	64.9
1990	172.0	170.6	163.7
1995	257.0	255.0	245.1
1996	224.6	224.5	214.0
1997	233.7	233.7	221.4
1998	249.8	249.8	236.0
1999 ¹	270.4	270.4	254.7
2000 ¹	291.8	291.3	273.1

¹Denominator File Data; HI and/or SMI as of July 1; HI and SMI represent person years.

NOTE: Data as of July 1.

SOURCE: CMS, Office of Research, Development and Information.

Table 5
Medicare enrollment/end stage renal disease demographics

	Number of enrollees (in thousands)
All persons	329.8
Age	
Under 35 years	28.4
35-44 years	38.6
45-64 years	123.2
65 years and over	139.6
Sex	
Male	178.5
Female	151.3
Race	
White	183.2
Other	145.3
Unknown	1.3

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2000.

SOURCE: CMS, Office of Research, Development and Information.

Table 6
Medicare managed care

	Number of Plans	Enrollees (in thousands)
Total prepaid	249	6,186
Medicare + Choice Programs	178	5,629
TEFRA Cost	31	299
Demonstrations	25	148
HCPPs ¹ Part B	15	109
Percent of total Medicare beneficiaries		15.6

¹Health care prepayment plans/group practice prepayment plans.

NOTES: Data as of May 1, 2001. Percent of total Medicare beneficiaries based on average monthly enrollment during calendar year 2001. Numbers may not add to totals because of rounding.

SOURCE: CMS, Center for Beneficiary Choices.

Table 7
Medicare enrollment/CMS region

	Resident ¹ population	Medicare ² enrollees	Enrollees as percent of population
In thousands			
All regions	281,422	38,782	13.8
Boston	13,923	2,123	15.2
New York	27,390	3,907	14.3
Philadelphia	27,820	4,161	15.0
Atlanta	53,252	8,009	15.0
Chicago	50,073	7,013	14.0
Dallas	33,264	4,043	12.2
Kansas City	12,920	1,974	15.3
Denver	9,327	1,102	11.8
San Francisco	42,213	5,012	11.9
Seattle	11,236	1,441	12.8

¹Estimated July 1, 2000 resident population.

²Medicare denominator enrollment file data are as of July 1, 2000.

NOTES: Resident population is a provisional estimate. The 2000 resident population data for Outlying Areas, Puerto Rico, and the Virgin Islands are not available.

SOURCES: CMS, Office of Research, Development and Information; U.S. Bureau of the Census, Population Division, Population Estimates Branch.

Table 8
Aged population/projected

	1998	2000	2025	2050	2075	2100
In millions						
65 years and over	34.9	35.2	60.5	76.9	90.9	102.2
75 years and over	16.1	16.6	24.6	40.6	49.6	57.8
85 years and over	4.2	4.4	5.9	14.6	17.7	22.5

SOURCE: Social Security Administration, Office of the Actuary.

Table 9
Life expectancy at age 65/trends

	Male	Female
Year	In years	
1965	12.9	16.3
1980	14.0	18.4
1985	14.4	18.6
1990	15.0	19.0
1995	15.6	19.0
1999 ¹	15.7	19.3
2000 ¹	15.8	19.3
2010 ¹	16.2	19.6
2020 ¹	16.6	19.9
2030 ¹	17.1	20.4
2040 ¹	17.5	20.9
2050 ¹	17.9	21.3
2060 ¹	18.2	21.7

¹Estimated.

SOURCE: Social Security Administration, Office of the Actuary.

Table 10
Life expectancy at birth and at age 65 by race/trends

Calendar Year	All Races	White	Black
	<u>At Birth</u>		
1950	68.2	69.1	60.7
1980	73.7	74.4	68.1
1985	74.7	75.3	69.3
1990	75.4	76.1	69.1
1995	75.8	76.5	69.6
1999 ¹	76.7	77.3	71.4
	<u>At Age 65</u>		
1950	13.9	NA	13.9
1980	16.4	16.5	15.1
1985	16.7	16.8	15.2
1990	17.2	17.3	15.4
1995	17.4	17.6	15.6
1999 ¹	17.7	17.8	16.0

¹Preliminary.

SOURCE: Public Health Service, Health United States, 2001.

Table 11
Medicaid person years and recipients

	Fiscal year					
	1990	1995	1999	2000	2001	2002
Person Years	In millions					
Total	22.9	33.4	32.8	33.4	33.9	34.3
Age 65 years and over	3.1	3.7	3.8	3.9	3.9	4.0
Blind/Disabled	3.8	5.8	6.6	6.7	6.8	6.9
Children	10.7	16.5	16.3	16.5	16.8	17.0
Adults	4.9	6.7	6.2	6.3	6.4	6.4
Other Title XIX	0.5	0.6	n/a	n/a	n/a	n/a
Recipients	In millions					
Total	25.3	36.3	41.0	41.7	42.3	42.8
Age 65 years and over	3.2	4.2	4.5	4.5	4.6	4.6
Blind/Disabled	3.7	6.0	7.3	7.4	7.6	7.7
Children	11.2	17.6	20.9	21.2	21.5	21.8
Adults	6.0	7.8	8.4	8.5	8.6	8.7
Other Title XIX	1.0	0.6	n/a	n/a	n/a	n/a

NOTES: Person years represent the monthly average enrollment during the fiscal year. Prior to 1995, recipient categories do not add to total because recipients could be reported in more than one category. Totals after 1990 may not add due to rounding. Aged and Blind/Disabled eligibility groups include Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB). Children and Adult groups include both AFDC/TANF and poverty level recipients who are not disabled. Recipient data for fiscal years 1990-1995 are historical data from OIS as reported by States. Projections for fiscal years 1999-2002 were prepared by OACT from the mid-Session Review of the President's 2002 budget. FY 1999-2002 do not include State Children's Health Insurance Program (SCHIP).

In 1997, the Other Title XIX category was dropped and the recipients therein were subsumed in the remaining categories. In 1998, Medicaid recipients were redefined to include eligibles on behalf of whom a capitation payment is paid. The large increase between 1995 and 1999 is primarily the result of this change of definition. These data may differ from other published program statistics because of differences in categorizing persons with unknown basis of eligibility.

SOURCES: CMS, Office of Information Services, Office of the Actuary, and the Center for Medicaid and State Operations.

Table 12
Medicaid eligibles/demographics

	Fiscal year 1999 Medicaid eligibles	Percent distribution
	In millions	
Total beneficiaries	42.0	100.0
Age	42.0	100.0
Under 21	22.7	54.0
21-64 years	13.0	30.9
65 years and over	4.8	11.4
Unknown	1.5	3.7
Sex	42.0	100.0
Male	16.3	38.8
Female	24.1	57.4
Unknown	1.6	4.8
Race	42.0	100.0
White, not Hispanic	18.1	43.1
Black, not Hispanic	10.8	25.7
American Indian/Alaska Native	0.5	1.2
Asian/Pacific Islander	1.1	2.5
Hispanic	7.0	16.7
Unknown	4.5	10.7

NOTES: Represents unduplicated number of persons ever enrolled during the year. Numbers may not add to totals because of rounding. The percent distribution of 1999 Medicaid eligibles is based on 1998 percent distributions. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, Center for Medicaid and State Operations.

Table 13
Medicaid average enrollment/CMS region

	Resident ¹ population	Average Medicaid ² enrollment	Enrollment as percent of population
In thousands			
All regions	272,691	32,325	11.9
Boston	13,496	1,727	12.8
New York	26,340	3,506	13.3
Philadelphia	27,119	2,946	10.9
Atlanta	51,020	6,864	13.5
Chicago	49,218	4,873	9.9
Dallas	32,065	3,562	11.1
Kansas City	12,657	1,285	10.2
Denver	8,916	605	6.8
San Francisco	40,917	5,749	14.1
Seattle	10,944	1,208	11.0

¹Estimated July 1, 1999 population. ²Medicaid beneficiary data are for fiscal year 1999 and represent Medicaid eligibles receiving either a capitated payment or covered care under fee-for-service any time during the year.

NOTES: Numbers may not add to totals because of rounding. Resident population is a provisional estimate. Excludes data for Puerto Rico, Virgin Islands and Outlying Areas.

SOURCES: CMS, Center for Medicaid and State Operations. U.S. Department of Commerce, Bureau of the Census.

Table 14
Medicaid beneficiaries/State buy-ins for Medicare

	1975	1980	² 1999	² 2000
Type of Beneficiary ¹	In thousands			
All buy-ins	2,846	2,954	5,392	5,549
Aged	2,483	2,449	3,563	3,632
Disabled	363	504	1,829	1,917
	Percent of SMI enrollees			
All buy-ins	12.0	10.9	14.5	14.9
Aged	11.4	10.0	11.0	11.1
Disabled	18.7	18.9	40.5	41.2

¹Beneficiaries for whom the State paid the SMI premium during the year. Percent calculated using July enrollment. ²Beneficiaries in person years.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Research, Development and Information.

Providers/Suppliers

Information about institutions, agencies, or professionals who provide health care services and individuals or organizations who furnish health care equipment or supplies

These data are distributed by major provider/supplier categories, by geographic region, and by type of program participation. Utilization data organized by type of provider/supplier may be found in the Utilization section.

Table 15
Inpatient hospitals/trends

	1975	1980	2000	2001
Total hospitals	6,707	6,777	5,985	6,031
Beds in thousands	1,132	1,150	991	983
Beds per 1,000 enrollees ¹	51.5	46.7	25.6	25.4
Short-stay	6,084	6,104	4,900	4,704
Beds in thousands	884	991	873	863
Beds per 1,000 enrollees ¹	40.2	40.2	22.5	22.3
Psychiatric	358	408	562	519
Beds in thousands	207	131	72	69
Beds per 1,000 enrollees ¹	9.4	5.3	1.9	1.8
Other long-stay	265	265	532	808
Beds in thousands	42	28	46	51
Beds per 1,000 enrollees ¹	1.9	1.1	1.2	1.3

¹ Based on number of aged HI enrollees.

NOTES: Facility data as of July 1, except 2000 and 2001 data which are as of December 1999 and December 2000, respectively. Facilities certified for Medicare are deemed to meet Medicaid standards. Hospitals formerly classified as short-stay and now defined as critical access are included in other long-stay.

SOURCE: CMS, Office of Research, Development and Information.

Table 16
Medicare assigned claims/CMS region

	Net assignment rates		
	1980	1999	2000
All regions	51.5	97.6	97.9
Boston	67.4	98.4	98.5
New York	51.8	97.6	97.9
Philadelphia	61.6	98.3	98.5
Atlanta	52.3	97.8	98.2
Chicago	47.6	97.7	97.9
Dallas	50.3	97.4	97.9
Kansas City	40.4	96.9	97.3
Denver	39.5	96.4	96.8
San Francisco	53.2	98.5	98.7
Seattle	31.3	89.0	89.8

NOTE: Calendar year data.

SOURCE: CMS, Office of Financial Management.

Table 17
Medicare hospital status

Total hospitals	6,940
Hospitals under Prospective Payment System (PPS)	5,326
PPS Hospitals receiving special consideration	1,340
Regional referral centers ¹	213
Sole community hospitals	717
Sole community/regional referral center	77
Medicare dependent hospitals	333
PPS Hospitals not receiving special consideration	3,986
Non-PPS hospitals	1,614
Categorically exempt	1,488
Psychiatric	507
Rehabilitation	210
Christian Science	15
Childrens	77
Other long-term	260
Critical Access	419
Alcohol/drug	0
Other reasons exempt	126
Short-stay hospitals in waiver State (Maryland)	68
Short-stay Indian Health Service hospitals	48
Cancer hospitals	10
Total excluded units	2,372
Psychiatric	1,446
Rehabilitation	926

¹Total number of hospitals subject to PPS regardless of actual submitted inpatient hospital claims during the fiscal year.

NOTE: Data as of July 2001.

SOURCES: CMS, Center for Medicare Management; Center for Medicaid and State Operations; Office of Clinical Standards and Quality; Office of Information

Table 18
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs ¹	Nursing Facilities	IMRs ²
All regions ³	14,841	2,116	6,767
Boston	1,089	49	180
New York	1,031	4	758
Philadelphia	1,393	126	450
Atlanta	2,571	189	727
Chicago	3,221	522	1,665
Dallas	1,751	554	1,525
Kansas City	1,192	459	191
Denver	595	69	91
San Francisco	1,511	105	1,096
Seattle	487	39	84

¹Skilled nursing facilities.

²Institutions for mentally retarded.

³All regions' totals include U.S. Possessions and Territories.

NOTE: Data as of December 2000.

SOURCE: CMS, Office of Research, Development and Information.

Table 19
Other Medicare providers and suppliers/trends

	1975	1980	2000	2001
Home health agencies	2,242	2,924	7,857	7,099
Clinical Lab Improvement Act Facilities	-	-	171,018	168,333
End stage renal disease facilities	-	999	3,787	3,991
Outpatient physical therapy	117	419	2,867	2,874
Portable X-ray	132	216	666	675
Rural health clinics	-	391	3,453	3,334
Comprehensive outpatient rehabilitation facilities	-	-	522	518
Ambulatory surgical centers	-	-	2,894	3,147
Hospices	-	-	2,326	2,267

NOTES: Facility data for selected years 1975-1980 are as of July 1. Facility data for 2000 and 2001 are as of December 1999 and December 2000, respectively.

SOURCE: CMS, Office of Research, Development and Information.

Table 20
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	4,704	14,841	7,099
	Percent of total		
Non-profit	59.9	28.3	36.0
Proprietary	13.8	66.4	48.1
Government	26.3	5.3	15.9

NOTES: Data as of December 2000. Facilities certified for Medicare are deemed to meet Medicaid standards. Percent distribution may not add to 100 percent due to rounding.

SOURCE: CMS, Office of Research, Development and Information.

Table 21
Periodic interim payment (PIP) facilities/trends

	1980	1985	1998	1999	2000
Hospitals					
Number of PIP	2,276	3,242	1,024	915	869
Percent of total participating	33.8	48.3	16.7	15.3	14.4
Skilled nursing facilities					
Number of PIP	203	224	1,396	1,387	1,236
Percent of total participating	3.9	3.4	9.3	9.3	8.3
Home health agencies					
Number of PIP	481	931	1,284	1,122	1,038
Percent of total participating	16.0	16.0	13.8	14.3	14.4

NOTES: Data from 1985 to date are as of September; 1980 data are as of December. These are facilities receiving periodic interim payments (PIP) under Medicare. Effective for claims received on or after July 1, 1987, the Omnibus Budget Reconciliation Act of 1986 eliminates PIP for many PPS hospitals when the servicing intermediary meets specified processing time standards.

SOURCE: CMS, Office of Financial Management.

Table 22
Physicians active in patient care/selected years

April 2000 January 2001

Number Percent Number

Percent

Active in Patient Care	854,224	100.0	865,479	100.0
Medical Specialties	167,652	19.6	171,894	19.9
Surgical Specialties	158,544	18.6	153,036	17.7
Other Specialties	86,417	10.1	88,613	10.2
Family and General Practice	100,928	11.8	101,449	11.7
Emergency Medicine	24,960	2.9	26,341	3.0
Pediatrics	28,104	3.3	26,079	3.0
Non-physician specialties	287,619	33.7	297,967	34.4

NOTES: Includes physicians, doctors of osteopathy, and limited licensed practitioners. Totals include physicians with unknown specialty.

SOURCE: CMS, Office of Research, Development and Information.

Table 23
Physicians/CMS region

	Physicians active in patient care	Physicians per 100,000 population
All regions	¹ 865,479	308
Boston	62,806	451
New York	105,719	339
Philadelphia	97,418	350
Atlanta	142,098	267
Chicago	147,636	295
Dallas	84,449	254
Kansas City	40,946	317
Denver	28,056	301
San Francisco	119,749	284
Seattle	36,591	326

¹Non-Federal physicians only. Includes physicians, doctors of osteopathy, and limited licensed practitioners. Total includes unknown geographic area.

NOTES: Physicians as of April 2001. Civilian population as of April 1, 2000.

SOURCES: CMS, Unique Physician Identification Number Directory; Office of Research, Development and Information, and the Bureau of the Census.

Table 24
Inpatient hospitals/CMS region

	Short-stay hospitals	Beds per 1,000 enrollees	Long-stay facilities	Beds per 1,000 enrollees
All regions	4,704	22.0	1,327	3.1
Boston	189	16.4	81	5.1
New York	350	25.3	84	5.2
Philadelphia	393	20.1	136	4.1
Atlanta	919	22.4	201	2.3
Chicago	837	24.4	199	2.6
Dallas	691	23.8	257	4.0
Kansas City	367	26.1	139	3.1
Denver	252	22.0	82	3.6
San Francisco	520	19.7	103	1.6
Seattle	186	16.6	45	1.9

NOTES: Data as of December 2000. Rates based on number of hospital insurance enrollees as of July 1, 2000.

SOURCE: CMS, Office of Research, Development and Information.

Expenditures

Information about spending for health care services by Medicare, Medicaid, and in the Nation as a whole

Health care spending at the aggregate levels is distributed by source of funds, types of service, geographic area, and broad beneficiary or eligibility categories. Direct out-of-pocket, other private, and non-CMS-related expenditures are also covered in this section. Expenditures on a per-unit-of-service level are covered in the Utilization section.

Table 25
CMS and total Federal outlays

	Fiscal year 2000	Fiscal year 2001
	\$ in billions	
Gross domestic product (current dollars)	\$9,744.3	\$10,150.5
Total Federal outlays ¹	1,788.8	1,863.9
Percent of gross domestic product	18.4	18.4
Dept. of Health and Human Services ¹	382.6	426.8
Percent of Federal Budget	21.4	22.9
CMS Budget (Federal Outlays)		
Medicare benefit payments	214.9	236.5
Medicare quinquennial adjustment ²	0.0	1.2
SMI transfer to Medicaid ³	0.0	0.1
Medicaid benefit payments ⁴	111.8	124.4
Medicaid State and local admin.	6.1	6.3
Medicaid offsets ⁵	0.0	-1.3
State Children's Health Ins. Prog. ⁶	1.2	3.7
CMS program management	1.9	2.1
Other Medicare admin. expenses ⁷	1.1	1.1
Quality improvement organizations ⁸	0.3	0.3
Health Care Fraud and Abuse Control	0.8	0.9
Total outlays (unadjusted)	338.1	375.3
Medicare premiums	-21.9	-23.7
Total net outlays	316.1	351.6
Percent of Federal budget	17.7	18.9

¹Outlays net of offsetting receipts.

²For military service wage credits.

³Reflects the SMI transfer of \$60 million to Medicaid for premium assistance.

⁴The costs of SCHIP-related Medicaid expansions are included in the FY 2000 Medicaid benefit payments. SCHIP-related Medicaid expansions began to be financed under SCHIP (Title XXI) in FY 2001.

⁵Medicaid offsets in FY 2001 include the SMI transfer of \$60 million to Medicaid for premium assistance and the SCHIP transfer of \$1.2 billion to reimburse the Medicaid program for the cost of SCHIP-related Medicaid expansions in fiscal years before FY 2001.

⁶The FY 2001 SCHIP amount includes the transfer of \$1.2 billion to Medicaid.

⁷Medicare administrative expenses of the Social Security Administration and other Federal agencies.

⁸Formerly peer review organizations (PROs).

NOTE: Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Financial Management.

Table 26
Program expenditures/trends

Fiscal year	Total	Medicare ¹ in billions	Medicaid ²	SCHIP ³
1980	\$60.8	\$35.0	\$25.8	--
1990	182.2	109.7	72.5	--
2000	428.7	219.0	208.0	\$1.7
2001	475.3	242.4	227.9	5.0

¹Medicare amounts are gross outlays for benefits and administration including Health Care Fraud and Abuse Control (HCFAC), quality improvement organizations and the SMI transfer to Medicaid for premium assistance. ²Medicaid amounts include Federal and State shares of benefit payments and State administrative costs, as well as outlays for the Vaccines for Children program. In FY 2001, the Medicaid amount is reduced to reflect the SCHIP transfer of \$1.2 billion and the SMI transfer of \$60 million for premium assistance. ³SCHIP amounts include Federal and State shares of Title XXI outlays.

SOURCE: CMS, Office of Financial Management.

Table 27
Benefit outlays by program

	1967	1968	2000	2001
Annually	Amounts in billions			
CMS program outlays	\$5.1	\$8.4	\$414	\$457
Federal outlays	NA	6.7	328	363
Medicare ¹	3.2	5.1	215	236
HI	2.5	3.7	126	136
SMI	0.7	1.4	89	101
Medicaid ²	1.9	3.3	197	217
Federal share ³	NA	1.6	112	124
SCHIP ^{4,5}	NA	NA	2	4
Federal share ⁵	NA	NA	1	2

¹Excludes expenditures for the quality improvement organizations. ²Includes Federal and State shares of benefit payments as well as outlays for the Vaccines for Children program. In FY 2000, includes the cost of SCHIP-related Medicaid expansions. ³The FY 2001 Federal share of Medicaid benefit payments is not reduced by the \$1.2 billion transfer from SCHIP and the SMI transfer of \$60 million for premium assistance. ⁴Includes Federal and State shares of Title XXI expenditures. ⁵Excludes the FY 2001 transfer of \$1.2 billion to Medicaid.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Financial Management.

Table 28
Program benefit payments/CMS region

Fiscal year 2000 benefit payments
Medicaid

	Medicare	Total payments computable for Federal funding	Net expenditures reported Federal share ¹
In millions			
All regions	\$214,868	\$195,506	\$111,002
Boston	11,568	13,132	6,875
New York	26,668	36,576	18,323
Philadelphia	24,162	18,876	10,408
Atlanta	46,413	29,592	18,663
Chicago	34,215	31,767	17,651
Dallas	23,995	18,468	12,167
Kansas City	8,867	8,035	4,907
Denver	5,142	7,283	4,759
San Francisco	28,314	24,645	13,182
Seattle	5,523	7,132	4,067

¹Excludes CMS adjustments.

NOTES: Data from Form HCFA-64 -- Line 11, Net Expenditures Reported. Medical assistance only. Territories are at capped levels. Excludes the State Childrens' Health Insurance Program (SCHIP).

SOURCES: CMS, Office of Financial Management; Office of the Actuary; and the Center for Medicaid and State Operations.

Table 29
Medicare benefit outlays

	Fiscal year		
	1999	2000	2001
In billions			
HI benefit payments	\$129.1	\$126.0	\$136.0
Aged	113.1	110.2	118.6
Disabled	16.0	15.8	17.4
SMI benefit payments	79.2	88.9	100.5
Aged	68.1	76.5	86.0
Disabled	11.1	12.4	14.5

NOTES: Excludes expenditures for the quality improvement organizations. Excludes the transfer from HI to SMI to finance a portion of home health services under Part B Medicare.

SOURCES: CMS, Office of Financial Management and the Office of the Actuary.

Table 30
Medicare/type of benefit

	Fiscal year 2001 benefit payments in millions	Percent distribution
Total HI	\$135,979	100.0
Inpatient hospital	93,236	68.6
Skilled nursing facility	12,426	9.1
Home health agency	4,061	3.0
Hospice	3,419	2.5
Managed care	22,837	16.8
Total SMI	100,514	100.0
Physician/other suppliers	40,380	40.2
Outpatient hospital	10,104	10.1
Durable medical equipment	5,263	5.2
Home health agency	5,241	5.2
Laboratory	4,357	4.3
Other fee-for-service	15,921	15.8
Managed care	19,249	19.2

NOTES: Benefits by type of service are estimated and are subject to change. Excludes expenditures for the quality improvement organizations. Excludes the transfer from HI to SMI to finance a portion of home health services under Part B Medicare. Totals do not necessarily equal the sum of rounded components.

SOURCES: CMS, Office of Financial Management and the Office of the Actuary.

Table 31
National health care/trends

	Calendar year			
	1965	1980	1999	2000
National total in billions	\$41.0	\$245.8	\$1,215.6	\$1,299.5
Percent of GDP	5.7	8.8	13.1	13.2
Per capita amount	\$205	\$1,067	\$4,377	\$4,637
Source of funds	Percent of total			
Private	75.1	57.3	54.8	54.8
Public	24.9	42.7	45.2	45.2
Federal	11.4	29.0	31.7	31.7
State/local	13.5	13.6	13.5	13.5

NOTE: Numbers may not add to totals because of rounding.

SOURCES: CMS, Office of the Actuary; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

Table 32
Medicaid/type of service

	Fiscal year		
	1998	1999	2000
	In billions		
Total vendor payments ¹	\$168.0	\$180.5	\$194.7
	Percent of total		
Inpatient services	14.7	14.1	14.1
General hospitals	13.3	12.8	12.8
Mental hospitals	1.4	1.3	1.3
Nursing facility services	20.4	20.2	20.3
Intermediate care facility (MR) services	5.9	5.3	5.1
Community-based long term care svcs. ²	8.9	9.1	9.4
Prescribed drugs ³	7.0	7.6	8.5
Physician services	3.9	3.6	3.5
Dental services	0.9	0.9	0.9
Outpatient hospital services	3.9	3.6	3.7
Clinic services ⁴	3.0	2.9	2.9
Laboratory and radiological services	0.3	0.3	0.3
Early and periodic screening	0.5	0.4	0.4
Targeted case management services	0.8	0.8	0.9
Capitation payments (non-Medicare)	13.7	15.1	15.3
Medicare premiums	2.3	2.3	2.1
Disproportionate share hosp. payments	8.9	8.6	7.4
Other services	4.9	5.0	4.9

¹Excludes payments under SCHIP. ²Comprised of home health, home and community-based waivers, personal care and home and community-based services for functionally disabled elderly. ³Net of prescription drug rebates. ⁴Federal qualified health clinics, rural health clinics and other clinics. NOTE: Data from Form HCFA-64 -- Line 6, Total Current Expenditures.

SOURCE: CMS, Center for Medicaid and State Operations.

Table 33
Medicare savings attributable to secondary payor provisions/type of provision

	Workers Comp.	Working Aged	ESRD	Auto	Disability	Total
1998	108.3	1,667.3	143.1	247.1	1,049.3	3,391.6
1999	97.1	1,700.0	162.9	241.0	1,156.5	3,554.6
2000	103.2	1,353.3	166.7	241.3	1,026.5	3,120.4

NOTES: Fiscal year data. In millions of dollars. FYs 1998 through 2000 totals include liability amounts of \$176.5 million, \$197.5 million, and \$229.4 million, respectively. Total includes other amounts not broken out in detail.

SOURCE: CMS, Office of Financial Management.

Table 34
Medicaid/payments by eligibility status

	Fiscal year 1999 vendor payments	Percent distribution
	In billions	
Total ¹	\$180.5	100.0
Age 65 years and over	48.9	27.1
Blind/disabled	68.3	37.8
Dependent children under 21 years of age	29.0	16.1
Adults in families with dependent children	18.7	10.4
Disproportionate share hospital and other unallocated payments	15.6	8.6

¹Excludes payments under State Children's Health Insurance Program (SCHIP).

SOURCE: CMS, Office of the Actuary.

Table 35
Medicare/durable medical equipment¹

Category	Allowed Charges ²	
	1999	2000
	In thousands	
Total	\$6,169,525	\$6,760,326
Surgical dressings	49,431	48,386
Supplies/accessories	81,172	99,769
Capped rental	1,141,233	1,265,667
Customized items	48,318	59,524
Oxygen	1,630,343	1,770,111
Prosthetics/orthotics	934,488	997,467
Inexpensive/routine	736,435	866,035
Items with frequent maintenance	166,814	154,751
Other	133,290	123,968
Parenteral/Enteral	726,116	723,019
DME to Admin. Drugs	570,154	711,094

¹Data are for calendar year.

²The allowed charge is the Medicare approved payment reported on a line item on the physician/supplier claim.

SOURCE: CMS, Center for Beneficiary Choices.

Table 36
National health care/type of expenditure

	National total in billions	Per capita amount		Percent Paid	
			Total	Medicare	Medicaid
Total	\$1,299.5	\$4,637	32.8	17.3	15.5
Health serv/suppl.	1,255.5	4,481	37.7	21.6	16.1
Personal health care	1,130.4	4,034	35.8	19.2	16.6
Hospital care	412.1	1,407	47.4	30.5	16.9
Prof. services	422.1	1,428	26.4	15.3	11.1
Phys./clinical	286.4	1,022	27.4	20.8	6.6
Nursing/home hlth.	124.7	445	55.3	15.0	40.3
Retail outlet sales	171.5	613	17.0	4.8	12.2
Admn. and pub. hlth.	125.1	447	17.0	5.8	11.2
Investment	43.9	157	--	--	--

NOTES: Data are as of calendar year 2000.

SOURCE: CMS, Office of the Actuary.

Table 37
Personal health care/payment source

	Calendar year			
	1970	1980	1999	2000
	In billions			
Total	\$63.2	\$214.6	\$1,062.6	\$1,130.4
	Percent			
Total	100.0	100.0	100.0	100.0
Private funds	64.8	59.7	56.9	56.7
Private health insurance	22.3	28.3	34.2	34.6
Out-of-pocket	39.7	27.1	17.4	17.2
Other private	2.8	4.3	5.3	5.0
Public funds	35.2	40.3	43.1	43.3
Federal	22.9	29.3	32.6	32.8
State and local	12.3	11.1	10.5	10.5

NOTE: Excludes administrative expenses, research, construction, and other types of spending that are not directed at patient care.

SOURCE: CMS, Office of the Actuary.

Utilization

Information about the use of health
care services

Utilization information is organized by persons receiving services and alternately by services rendered. Measures of health care usage include: persons served, units of service (e.g., discharges, days of care, etc.), and dimensions of the services rendered (e.g., average length of stay, charge per person or per unit of service). These utilization measures are aggregated by program coverage categories, provider characteristics, type of service, and demographic and geographic variables.

Table 38
Medicare/short-stay hospital utilization

	1985	1990	1999	2000
Discharges				
Total in millions	10.5	10.5	11.7	11.8
Rate per 1,000 enrollees ¹	347	313	303	300
Days of care				
Total in millions	92	94	71	71
Rate per 1,000 enrollees ¹	3,016	2,805	1,856	1,805
Average length of stay				
All short-stay	8.7	9.0	6.1	6.0
Excluded units ²	18.8	19.5	12.3	12.3
Total charges per day	\$597	\$1,060	\$2,496	\$2,720

¹The population base is HI enrollment excluding HI enrollees residing in foreign countries and should be treated as preliminary. ²Includes alcohol/drug, psychiatric, and rehabilitation units through 1990, and psychiatric and rehabilitation units for 1999 and 2000.

NOTE: Data may reflect under reporting due to a variety of reasons including: operational difficulties experienced by intermediaries; no-pay, at-risk managed care utilization; and no-pay Medicare secondary payer bills.

SOURCE: CMS, Office of Information Services.

Table 39
Medicare long-term care/trends

Calendar year	Skilled nursing facilities		Home health agencies	
	Persons served in thousands	Served per 1,000 enrollees	Persons served in thousands	Served per 1,000 enrollees
1982	252	9	1,172	40
1985	315	10	1,576	51
1990	638	19	1,978	58
1995	1,240	33	3,457	93
1996	1,384	37	3,627	95
1997	1,503	¹ 46	3,505	¹ 106
1998	1,447	¹ 45	3,062	¹ 95
1999	1,390	¹ 47	2,720	¹ 92

¹Managed care enrollees excluded in determining rate.

SOURCE: CMS, Office of Information Services.

Table 40
Medicare average length of stay/trends

	Fiscal year					
	1984	1990	1995	1998	1999	2000
All short-stay hospitals	9.1	9.0	7.1	6.2	6.1	6.0
PPS hospitals	8.0	8.9	7.1	6.2	6.1	6.0
Excluded units	18.0	19.5	14.8	12.9	12.3	12.3

NOTES: Fiscal year data. Average length of stay is shown in days. For all short-stay and PPS hospitals, 1984 data are based on a 20-percent sample of Medicare HI enrollees. Data for 1990 through 2000 are based on 100-percent MEDPAR. Data may differ from other sources or from the same source with a different update cycle.

SOURCE: CMS, Office of Information Services.

Table 41
Medicare persons served/trends

	Calendar year				
	1975	1980	1985	1998	1999
Aged persons served per 1,000 enrollees					
HI and/or SMI	528	638	722	918	921
HI	221	240	219	243	232
SMI	536	652	739	964	966
Disabled persons served per 1,000 enrollees					
HI and/or SMI	450	594	669	821	830
HI	219	246	228	206	198
SMI	471	634	715	925	936

NOTES: Prior to 1998, data were obtained from the Annual Person Summary Record. Beginning in 1998, utilization rates are based on persons receiving fee-for-service care and total persons not enrolled in prepaid health plans. For the period 1975-1996, users of hospice services were excluded.

SOURCES: CMS, Office of Information Services and the Office of Research, Development and Information.

Table 42
Medicare fee-for-service (FFS) persons served

	Calendar year				
	1995	1996	1997	1998	1999
	Numbers in millions				
HI					
Aged					
FFS Enrollees	29.4	28.9	28.1	27.3	27.0
Persons served	7.1	7.2	7.1	6.7	6.3
Rate per 1,000	241	249	254	243	232
Disabled					
FFS Enrollees	4.2	4.4	4.5	4.6	4.7
Persons served	0.9	1.0	1.0	1.0	0.9
Rate per 1,000	221	220	218	206	198
SMI					
Aged					
FFS Enrollees	28.4	27.9	27.0	26.2	25.9
Persons served	26.8	26.4	25.9	25.3	25.0
Rate per 1,000	943	947	959	964	966
Disabled					
FFS Enrollees	3.8	3.9	4.0	4.1	4.2
Persons served	3.5	3.6	3.7	3.8	3.9
Rate per 1,000	914	920	925	925	936

NOTES: Enrollment represents persons enrolled in Medicare fee-for-service as of July. Persons served represents estimates of beneficiaries receiving reimbursed services under fee-for-service during the calendar year.

SOURCE: CMS, Office of Research, Development and Information.

Table 43
Medicare persons served/CMS region

	Aged persons served in thousands	Served per 1,000 enrollees	Disabled persons served in thousands	Served per 1,000 enrollees
All regions ¹	25,274	921	3,937	830
Boston	1,308	838	206	837
New York	2,804	893	445	752
Philadelphia	2,711	912	390	861
Atlanta	5,378	919	992	903
Chicago	5,118	929	690	858
Dallas	2,636	893	432	859
Kansas City	1,483	930	193	885
Denver	748	958	103	837
San Francisco	2,249	889	363	803
Seattle	843	958	123	872

¹Includes utilization for residents of foreign countries.

NOTES: Data as of calendar year 1999 for persons served under HI and/or SMI. Based on utilization for fee-for-service and excludes utilization under alternative payment systems such as health maintenance organizations. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Research, Development and Information.

Table 44
Medicare/end stage renal disease (ESRD)

	Calendar year		
	1998	1999	2000
Total enrollees ¹	277,826	270,438	290,884
Dialysis patients ²	245,710	259,493	273,333
Outpatient	216,310	231,032	245,207
Home	29,400	28,461	28,126
Transplants performed ³	13,272	13,483	14,311
Living donor	3,453	3,583	4,052
Cadaveric donor	8,752	8,839	8,884
Living unrelated	1,067	1,061	1,375
Average dialysis payment rate	\$127	\$127	\$127
Hospital-based facilities	\$129	\$129	\$129
Freestanding facilities	\$125	\$125	\$125

¹Medicare ESRD enrollees as of July 1.

²Includes Medicare and non-Medicare patients receiving dialysis as of December 31.

³Includes kidney transplants for Medicare and non-Medicare patients.

SOURCES: CMS, Office of Clinical Standards and Quality and the Office of Research, Development and Information.

Table 45
Medicaid/type of service

	Fiscal year 1999 Medicaid beneficiaries In thousands
Total eligibles	42,062
Number using service:	
Total beneficiaries, any service	40,172
Inpatient services	
General hospitals	4,528
Mental hospitals	127
Nursing facility services ¹	1,654
Intermediate care facility (MR) services ²	121
Physician services	18,419
Dental services	5,673
Other practitioner services	4,026
Outpatient hospital services	12,324
Clinic services	6,632
Laboratory and radiological services	10,237
Home health services	830
Prescribed drugs	19,784
Personal care support services	4,106
Sterilization services	123
PCCM services	3,855
Prepaid health care	20,556
Other care	9,193
Unknown	132

¹Nursing facilities include: SNFs and all categories of ICF, other than "MR".

²"MR" indicates mentally retarded.

NOTE: Beginning in 1998, beneficiary counts include Medicaid eligibles enrolled in Medicaid Managed Care Organizations.

SOURCE: CMS, Center for Medicaid and State Operations.

Table 46
Medicaid/units of service

	Fiscal year 1998 units of service ¹ In thousands
General hospital ¹	
Total discharges	3,971
Recipients discharged	2,793
Total days of care	19,091
Nursing facility ²	
Total days of care	384,549
Intermediate care facility/mentally retarded ³	
Total days of care	50,636

¹Preliminary.

²Based on reporting States and the District of Columbia (Data are not reported for Nebraska, West Virginia and Puerto Rico).

³Based on reporting States and the District of Columbia (Data are not reported for Arizona, Nebraska, Oklahoma, Tennessee, West Virginia, Virgin Islands and Puerto Rico).

NOTE: Nursing facilities include: SNFs and all categories of ICF, other than mentally retarded.

SOURCE: CMS, Center for Medicaid and State Operations.

Administrative/Operating

Information on activities and services related to oversight of the day-to-day operations of CMS programs

Included are data on Medicare contractors, contractor activities and performance, CMS and State agency administrative costs, quality control, and summaries of the operation of the Medicare trust funds.

Table 47
Medicare administrative expenses/trends

	Administrative expenses	
	Amount in millions	As a percent of benefit payments
HI Trust Fund		
1967	\$89	3.5
1970	149	3.1
1975	259	2.5
1980	497	2.1
1985	813	1.7
1990	774	1.2
1995	1,300	1.1
1999	¹ 1,979	1.5
2000	¹ 2,350	1.9
SMI Trust Fund		
1967	² 135	20.3
1970	217	11.0
1975	405	10.8
1980	593	5.8
1985	922	4.2
1990	1,524	3.7
1995	1,722	2.7
1999	1,510	1.9
2000	1,780	2.0

¹Includes non-expenditure transfers for Health Care Fraud and Abuse Control.

²Includes expenses paid in fiscal years 1966 and 1967.

NOTE: Fiscal year data.

SOURCE: CMS, Office of the Actuary.

Table 48
Medicare contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	27	15
Other	2	5

NOTE: Data as of April 2001.

SOURCE: CMS, Office of Financial Management.

Table 49
Medicare appeals

	Intermediary reconsiderations	Carrier reviews
Number processed	47,805	3,344,925
Percent with increased payments ¹	29.1	65.0

¹Excludes withdrawals and dismissals.

NOTE: Data for fiscal year 2000.

SOURCE: CMS, Office of Financial Management.

Table 50
Medicare claims processing bottom line unit costs

	Unit cost per claim				
	1975	1980	1998	1999	2000
Intermediaries ¹	\$3.84	\$2.96	\$0.92 ³	\$0.76 ³	\$0.86 ³
Carriers ²	2.90	2.33	0.91	0.60	0.63

¹Includes direct costs and overhead costs for bill payment, reconsiderations, and hearings lines. ²Includes direct costs and overhead costs for the claims payment, reviews and hearings, and beneficiary/physician inquiries lines. ³Beginning in FY 1998, inquiries and PET activities are separated from other bill payment cost for intermediaries.

NOTE: Fiscal year data.

SOURCE: CMS, Office of Financial Management.

Table 51
Medicare claims processing

	Intermediaries	Carriers
Claims processed in millions	150.8	740.2
Total PM costs in millions	\$302.7	\$917.2
Total MIP costs in millions	\$359.4	\$264.8
Claims processing costs in millions	\$167.1	\$587.2
Claims processing unit costs	\$0.86	\$0.63
Range		
High	\$1.35	\$1.45
Low	\$0.70	\$0.58

NOTES: Data for fiscal year 2000. PM= Program Management. MIP= Medicare Integrity Program. These figures do not include Y2K costs. Due to Y2K activities, some system work was deferred resulting in lower claims processing and total costs than would otherwise have materialized.

SOURCE: CMS, Office of Financial Management.

Table 52
Medicare claims received

	Claims received
Intermediary claims received in thousands	153,958
	Percent of total
Inpatient hospital	9.2
Outpatient hospital	45.9
Home health agency	7.6
Skilled nursing facility	2.4
Other	34.9
Carrier claims received in thousands	720,922
	Percent of total
Assigned	97.9
Unassigned	2.1

NOTE: Data for calendar year 2000.

SOURCE: CMS, Office of Financial Management.

Table 53
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	615.9	12.6
Percent reduced	87.9	78.6
Total covered charges		
Amount in millions	\$126,391	\$1,287
Percent reduced	47.7	18.0
Amount reduced per claim	\$98.19	\$18.19

NOTES: Data for calendar year 2000. As a result of report changes effective April 1, 1992, charge reductions include: reasonable charge, medical necessity, and global fee/rebundling reductions.

SOURCE: CMS, Office of Financial Management.

Table 54
Medicaid administration

	Fiscal year	
	1999	2000
	In thousands	
Total payments computable for Federal funding ¹	\$9,494,049	\$10,577,848
Federal share of current expenditures:		
Family planning	14,199	9,833
Design, development or installation of MMIS ²	118,731	72,353
Skilled professional medical personnel	247,156	244,293
Operation of an approved MMIS ²	767,701	790,760
Other financial participation	4,103,939	4,699,336
Mechanized systems not approved under MMIS ²	72,562	76,022
Total administration	\$5,324,288	\$5,892,597
Net adjusted Federal share ³	\$5,266,760	\$5,730,796

¹Source: Form HCFA-64.10, Expenditures for State and Local Administration for the Medical Assistance Program (net expenditure reported). FY 2000 data are preliminary (03/2001).

²Medicaid Management Information System.

³Includes Federal share of net expenditures reported plus CMS adjustments.

Sources: CMS, Center for Medicaid and State Operations and the Office of Financial Management.

Reference

Selected reference material including cost-sharing features of the Medicare program, program financing, and Medicaid Federal medical assistance percentages

Program financing

Medicare/source of income

Hospital Insurance trust fund:

1. Payroll taxes*
2. Transfers from railroad retirement account
3. General revenue for
 - a. uninsured persons
 - b. military wage credits
4. Premiums from voluntary enrollees
5. Interest on investments

*Contribution rate	2000	2001	2002
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90
Maximum taxable amount (CY 2002)			None ¹

Voluntary HI Premium²

Monthly Premium (2002): \$319

Supplementary Medical Insurance trust fund:

1. Premiums paid by or on behalf of enrollees
2. General revenue
3. Interest on investments

Part B Premium

Monthly Basic Premium (2002): \$54.00

Medicaid/financing

1. Federal contributions (ranging from 50 to 76.82 percent for fiscal year 2002)
2. State contributions (ranging from 23.18 to 50 percent for fiscal year 2002)

¹The Omnibus Reconciliation Act of 1993 eliminated the Annual Maximum Taxable Earnings amounts for 1994 and later. For these years, the contribution rate is applied to all earnings in covered employment.

²Premium paid for voluntary participation of individuals aged 65 and over not otherwise entitled to hospital insurance and certain disabled individuals who have exhausted other entitlement. A reduced premium of \$175 is available to individuals aged 65 and over who are not otherwise entitled to hospital insurance but who have, or whose spouse has or had, at least 30 quarters of coverage under Title II of the Social Security Act.

SOURCE: CMS, Office of the Actuary.

Medicare deductible and coinsurance amounts

Part A (effective date)	Amount
Inpatient hospital deductible (1/1/02)	\$812/benefit period
Regular coinsurance days (1/1/02)	\$203/day for 61st thru 90th day
Lifetime reserve days (1/1/02)	\$406/day (60 nonrenewable days)
SNF coinsurance days (1/1/02)	\$101.50/day after 20th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/02)	\$319/month \$175/month if have at least 30 quarters of coverage

Limitations:

Inpatient psychiatric hospital days	190 nonrenewable days
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Part B (effective date)	Amount
Deductible (1/1/91) ¹	\$100 in reasonable charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance ¹	20 percent of allowed charges
Premium (1/1/02)	\$54.00/month

Limitations:

Outpatient treatment for mental illness	No limitations
Licensed physical therapist's services in home or office (1/1/91)	\$600 (80% of maximum annual program payment of \$750)

¹The Part B deductible and coinsurance applies to most services. Items and/or services not subject to either the deductible or coinsurance are clinical diagnostic lab tests subject to a fee schedule, home health services, items and services furnished in connection to obtaining a second or third opinion, influenza vaccine and its administration, and pneumococcal vaccine and its administration. In addition, federally qualified health center services are not subject to the deductible but are subject to the coinsurance.

SOURCE: CMS, Office of the Actuary.

**Geographical jurisdictions of CMS regional offices and
Federal medical assistance percentages (FMAP)
fiscal year 2002**

I.	Boston	FMAP	II.	New York	FMAP
	Connecticut	50		New Jersey	50
	Maine	67		New York	50
	Massachusetts	50		Puerto Rico	50
	New Hampshire	50		Virgin Islands	50
	Rhode Island	52		Canada	--
	Vermont	63			
			IV.	Atlanta	
III.	Philadelphia			Alabama	70
	Delaware	50		Florida	56
	Dist. of Columbia	70		Georgia	59
	Maryland	50		Kentucky	70
	Pennsylvania	55		Mississippi	76
	Virginia	51		North Carolina	61
	West Virginia	75		South Carolina	69
				Tennessee	64
V.	Chicago		VI.	Dallas	
	Illinois	50		Arkansas	73
	Indiana	62		Louisiana	70
	Michigan	56		New Mexico	73
	Minnesota	50		Oklahoma	70
	Ohio	59		Texas	60
	Wisconsin	59			
VII.	Kansas City		VIII.	Denver	
	Iowa	63		Colorado	50
	Kansas	60		Montana	73
	Missouri	61		North Dakota	70
	Nebraska	60		South Dakota	66
				Utah	70
IX.	San Francisco			Wyoming	62
	Arizona	65	X.	Seattle	
	California	51		Alaska	57
	Hawaii	56		Idaho	71
	Nevada	50		Oregon	59
	American Samoa	50		Washington	50
	Guam	50			
	N. Mariana Islands	50			

SOURCE: CMS, Center for Medicaid and State Operations.

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